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Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

TREATMENT

REHABILITATION

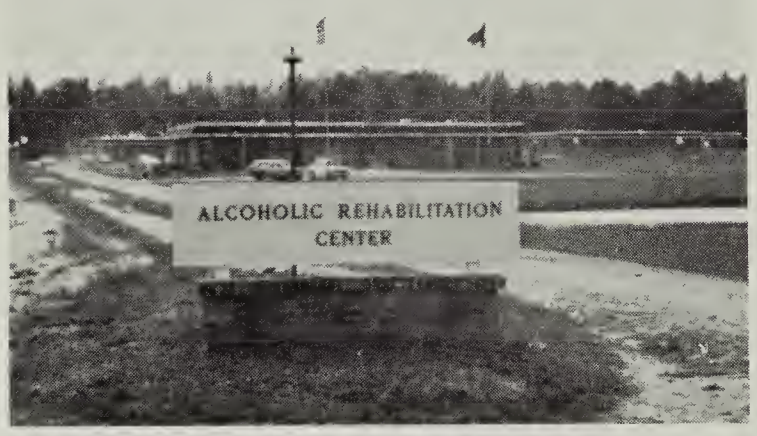
EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTERS

ARC at Butner, North Central Region

ARC at Black Mountain, Western Region



ARC at Greenville, Eastern Region

About the ARC's . . .

The ARC's, operated by the N. C. Department of Mental Health, are in-residence treatment facilities for persons with alcoholism. For the majority of patients the length of stay is 28 days. A fee of $7 per day is charged for the four weeks of treatment. This may be paid by cash or check at the time of admission or by an agreement signed by the patient promising to pay the full sum at some time after discharge. If a person is indigent he may obtain a letter from his local department of social service stating this fact and, upon presentation of this letter, request for payment will be deferred. No patients are refused treatment because of lack of money.

ARC Treatment Methods . . .

The basic treatment program includes medical care, education about alcohol and alcoholism, group psychotherapy, individual therapy, when needed, and referral for continued treatment. Rehabilitative therapies include occupational, recreational and industrial therapy, vocational counseling, spiritual counseling, on request, and the opportunity to participate in the fellowship of Alcoholics Anonymous.

More detailed information on the treatment program and admission requirements may be obtained by writing the respective centers. The counties of the various regions follow:

Eastern Region

Beaufort	Gates	Onslow
Bertie	Greene	Pamlico
Brunswick	Halifax	Pasquotank
Camden	Hertford	Pender
Carteret	Hyde	Perquimans
Chowan	Jones	Pitt
Craven	Lenoir	Tyrrell
Currituck	Martin	Washington
Dare	Nash	Wayne
Duplin	New Hanover	Wilson
Edgecombe	Northampton	

North Central Region

Alamance	Franklin	Rockingham
Caswell	Granville	Stokes
Chatham	Guilford	Surry
Durham	Orange	Vance
Forsyth	Person	Warren
		Yadkin

Western Region

Alexander	Clay	McDowell
Alleghany	Cleveland	Macon
Ashe	Gaston	Madison
Avery	Graham	Mecklenburg
Buncombe	Haywood	Mitchell
Burke	Henderson	Polk
Caldwell	Iredell	Rutherford
Catawba	Jackson	Swain
Cherokee	Lincoln	Transylvania
		Watauga

Wilkes and Yancey

The ARC's

For an appointment contact the Admitting Office at:

Western Region

ARC (Just off Old Highway 70 east of Western N. C. Sanatorium); P. O. Box 1058, Black Mountain 28711; Tel: (704) 669-6481.

North Central Region

ARC (12 miles north of Durham off Highway 15); West E. Street, Butner 27509; Tel: (919) 985-6541.

Eastern Region

ARC (Highway 43 west of Greenville); P. O. Box 2276, Greenville 27834; Tel: 758-3151.

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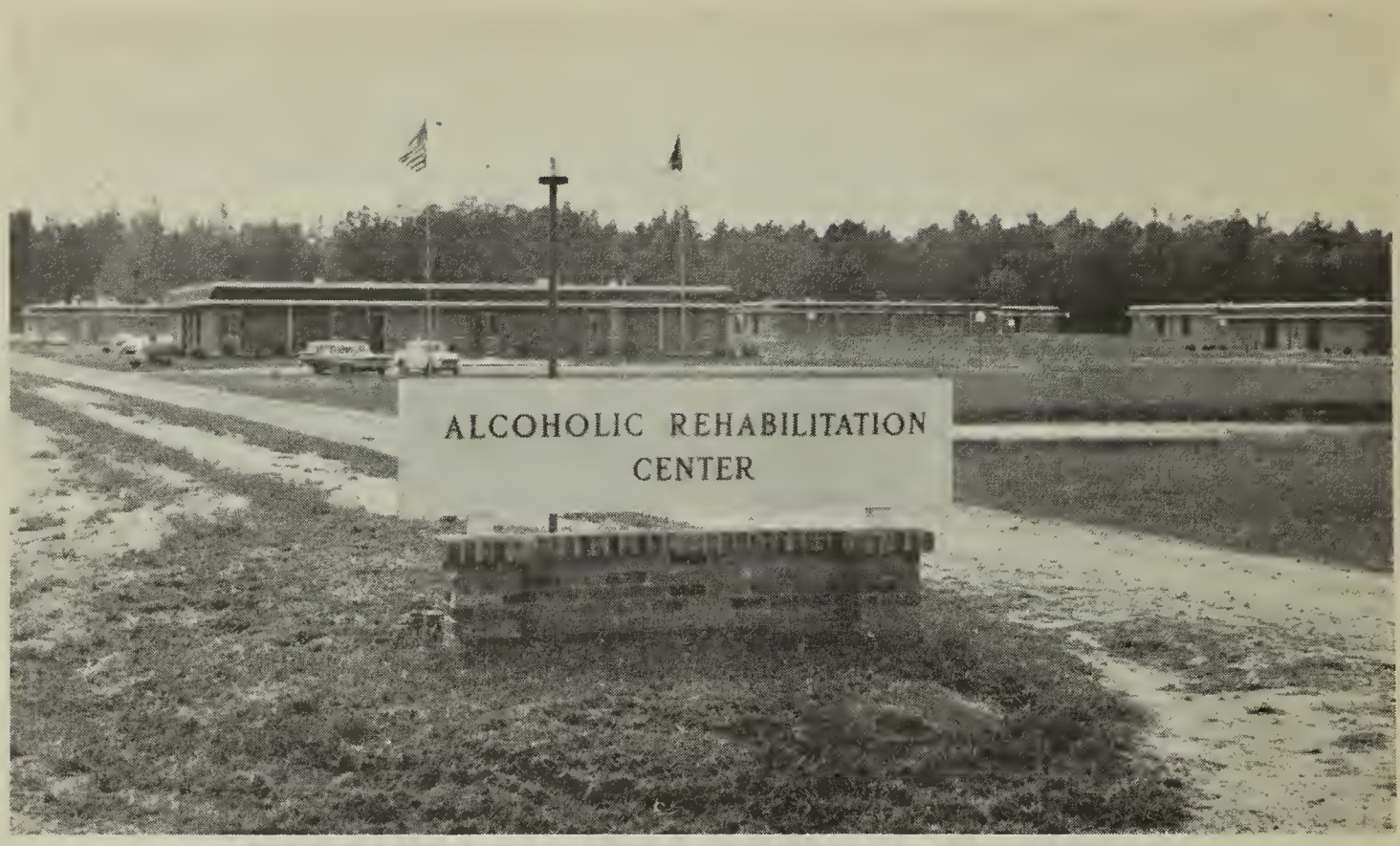


The ARC at Greenville, serving the 32 counties of the Eastern Region, is located on Highway 43 west of Greenville on a 30-acre lot.

Serving the Eastern Region

ARC AT GREENVILLE

IS an alcoholic rehabilitation center only an alcoholic rehabilitation center? Not necessarily. If the Alcoholic Rehabilitation Center, Greenville, North Carolina develops according to plan, it will be much more than "just" an alcoholic rehabilitation center.

First, it will be a training center as well as a treatment and rehabilitation center. Already affiliations have either been established or are in the process of being worked out with East Carolina University for the center to receive student nurses, social workers and psychologists, recreators and counselors for training and field work. A contract is presently being negotiated with the Division of Vocational Rehabilitation to use the center for field training

A view of the Therapy Building.

of its "interns" in patient services, patient evaluation, discharge planning and follow up. People who are already working with alcoholics in some capacity in the 32 counties it serves will be trained there.

Finally, perhaps the most ambitious plans are for the center to serve as a hub around which comprehensive services for alcoholics and their families can be developed regionwide at the community level.

The Greenville ARC is the third of three centers to open this year that were built with the proceeds of a 1965 legislative increase of five cents a bottle on alcoholic beverages sold in State ABC stores. Operated by the North Carolina Department of Mental Health, the center will serve the Eastern Region as an integral component of the concept of comprehensive regional mental health services which is currently the main thrust of the department's program. The foundation for implementing the alcoholism component in the east is the staffing pattern of the center which ties program development at the center to program development in the region.

One of three "patient cottages."

The link is a regional program director who, in conjunction with other professional staff and the deputy commissioner on alcoholism of the Department of Mental Health, Dr. R. J. Blackley, is responsible for developing the best possible treatment and rehabilitation program at the center and, also, a comprehensive

Key staff members of the ARC are (left to right): Edgar Bass, administrative assistant; Donald Watson, social worker; Dr. John M. Gambill, clinical director; Donald R. Dancy, program director; Joel E. Vickers, business manaper; Mrs. Phyllis Martin, chief of nursing service; and J. H. Waldrop, Jr., rehabilitation services coordinator.

network of local services for alcoholics and their families.

The regional program director is Don Dancy, former director of the alcoholism program of the West Virginia Department of Mental Health. Dancy, also, is a former director of the Asheville, N. C. Alcohol Information Center. He has one staff member, Howard Dawkins, who will work as "regional coordinator" and spend full time on community work. "We'll work with any community resource —alcoholism, mental health, public health, social service, education, interested citizens—to develop this comprehensive network of services," Dancy said. "Our aim is for the regional facilities—the ARC and the Alcoholism Unit at Cherry Hospital—to become just two of many resources in a comprehensive network of services including precare, inpatient treatment, aftercare and education, counseling and referral services at the community level."

Counties Served

The counties of the Eastern Region are: Beaufort, Bertie, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford and Hyde. Also, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, Washington, Wayne and Wilson.

The ARC at Greenville opened its doors on June 30, 1969. As of September 15, 1969 ninety patients had been treated and the patient census on that day was forty. It's capacaty is 88 patients.

Dr. John Gambill, medical director, explained the criteria for admission. "We take only voluntary patients on referral from a private physician," he said. "The patient, in order to be admitted, must: 1) have 72 hours sobriety; 2) live in one of the 32 eastern counties; 3) have no court action pending; 4) bring a letter from the referring physician with him recommending admission and stating that he is free from major physical and mental disease; and 5) have the referring physician telephone the admissions officer and make an appointment for admission."

The admitting days are Thursday, Friday, Monday and Tuesday.

All patients are admitted through the infirmary for physical, mental and social evaluation. They may remain in the infirmary 7-10 days, according to each patient's need. First they receive a thorough physical examination which routinely includes: kidney and liver studies; F.B.S. (Fasting Blood Sugar); urinalysis; Wasserman; C.B.C. (Complete Blood Count); and a chest X-ray. Also, during this time, the psychologist, by testing the patient, and a social worker, by interviewing the patient and family members, obtains pertinent psychological and social data for a later diagnosis. Appropriate withdrawal treatment as well as other medical treatment is prescribed, as needed, and orientation about the center and its treatment begins.

On Wednesday, key staff members meet and conduct a diagnostic review of all patients admitted the previous week, and assign each patient to a course of treatment designed to meet his particular needs. At the same meeting, a discharge plan is made for all patients who are ready to leave. This group of staff members, known as the Diagnostic Staff, includes the regional program director, physician, rehabilitation cocrdinator, psychologist, occupational therapist and a nurse and two social workers.

The types of inpatient therapy and other activities to which the patients

may be assigned include: intensive group therapy, educational milieu therapy, individual counseling, occupational and industrial therapy, vocational counseling, recreational activities and spiritual counseling on request of patient.

When patient government meets on Wednesday a representative of the Diagnostic Staff is invited for all or part of the session. On Wednesday at the Diagnostic Staff meeting a representative of patient government is extended a similar invitation.

Voluntary activities in which the patients may participate include the fellowship of Alcoholics Anonymous which meets at the center on Wednesday evenings. The meetings are arranged by the Pitt County Alcohol Information and Service Center. Patients may attend church services in the community on Sunday mornings, and two Sunday School classes are taught at the center by volunteers from the community churches.

Participation in routine housekeeping duties is required of all patients. Assignments to duties are made by the staff after the doctor has made his physical evaluation of the patient. Saturday is general "clean up day."

The infirmary has its own laboratory which is equipped to handle all routine lab work.

Dry cleaning, haircuts and sets are available to patients from local establishments at the patient's expense. The center arranges transportation as needed, and presently runs a "shopping service" to get personal items for patients. In addition patients may purchase such items as toothbrushes, toothpaste, stationery, etc. at the center from a "PX" type

Picnic and camping facilities are being developed in this area on the center's grounds.

store.

Recreation activities take place on and off the grounds. On-grounds recreation includes fishing in the pond, picnicking and plug golf. The center has plans for building a composition court and camping facilities in the future. Off-grounds activities include miniature golf, bowling and movies.

On Thursday the families of the patients are invited to attend "family group therapy day." Those that do may also visit their patient. Otherwise visiting is confined to Sunday afternoon only. Home visits by the patients are permitted by permission of the medical director only.

In discharge planning, the patient may be released on Antabuse therapy when applicable and/or referred to community resources for continued treatment. These resources may include the local mental health clinics, alcohol information centers, social service departments, Alcoholics Anonymous or other agencies. The Pitt County Flynn Home, for example, has taken homeless men who otherwise had no place to go.

Recommended Stay

The length of stay varies, but four to five weeks is recommended as a minimum. The cost is $7.00 per day. Patients who are unable to pay the full amount on discharge may make arrangements for extended terms directly with the business office. Indigent patients are not expected to pay for treatment.

If, in an emergency or in the case of serious physical illness, it becomes necessary to transfer a patient to Pitt Memorial Hospital, the patient pays all medical and hospital charges.

The center, located on Highway 43 west of Greenville, is housed in seven buildings. The complex consists of an administration building, dining hall, therapy building, three patient cottages and an infirmary built on a 30-acre lot.

The infirmary has its own laboratory and X-ray room. The laboratory is equipped to handle all routine lab work, while the X-ray room has a 14 by 17 X-ray machine and dark room for developing film. The X-ray pictures are read and interpreted by physicians at the Eastern North Carolina Sanatorium at Wilson.

The patient cottages are equipped with a washing machine and dryer, ironing board and iron, television in the lounge and kitchenette and snack area including a sizable coffee pot. After the patients are released from the infirmary, they are assigned to the cottages according to the district from which they come. There are three districts, one to a cottage, composed as nearly as possible of the counties served by the same mental health area programs.

The center employs its own specialty staff, some of whom are also affiliated with, or on the staff of, East Carolina University. In addition to the regional program director, regional coordinator, physician and business manager, the specialized personnel includes a psychologist, chaplain, laboratory technician who also doubles as X-ray technician, social workers and nurses. The Pitt Technical Institute provides the technical staff to operate the occupational and industrial therapy program. Additional professional services, particularly in the areas of psychology, social work and recreation, are contracted from ECU. Arrangements are being completed with the Division of Vocational Rehabilitation for vocational rehabilitation services.

Although the center employs only one full-time physician, continuous medical coverage is provided with

Guy Sumpter, food services supervisor, and Mrs. Hattie Manning, helper, survey the dining hall.

the help of 18 private physicians from the community. For a modest fee, these physicians, according to a schedule, are on call nights and week ends or anytime Dr. Gambill is off duty or on vacation.

Of major importance to the professional staff, in its efforts to provide the best possible treatment, to the patients' welfare, as well as to the smooth operation of the center is the assistance and support of the secretarial, attendant, dietary, housekeeping and maintenance personnel.

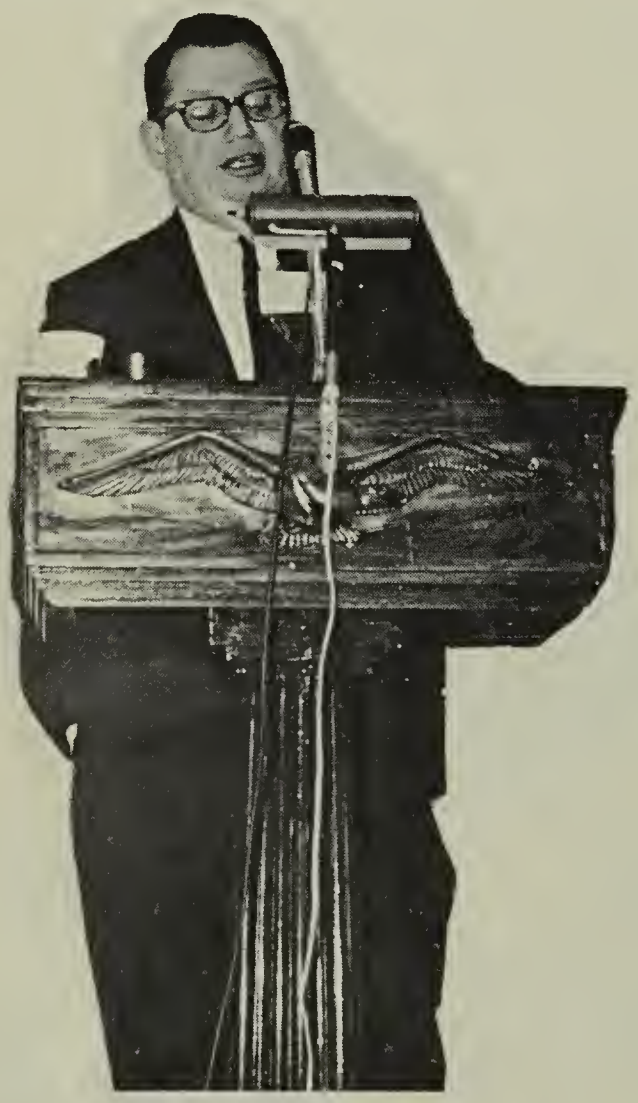
Two other features that greatly aid the staff and patients are the center-wide public address and central dictating systems. The former is used to locate staff members and play background music throughout the center. The latter consists of "instant" dictating machines that are strategically located in interview, counseling and observation rooms for the use of the professional staff. Immediately after sessions with the patients, the therapist or counselor can dictate his impressions which are recorded by a central machine and stored either for instant or later transcription by a secretary.

In summarizing operations at the center, Dancy said, "We expect to accomplish all our goals in time, but first we must be sure of what we are doing at the center. Our next job is to build mutually rewarding relationships and bridges of understanding with all the communities involved. Hopefully, we'll do this through the educational process of community involvement. Then we'll be able to come up with, and execute, a plan for developing the needed services at the community level."

"However," Dancy concluded, "if our experience in Pitt County, our homesite, is any indication, our job should be an easy one." He was referring to the examples of community involvement that are already apparent in the cooperation of East Carolina University, Pitt Technical Institute, local physicians, the Pitt County Alcohol Information and Service Center, Alcoholics Anonymous, local churches and the Flynn Home, among others.

Constant energetic activity typifies the nursing station in the infirmary.

UNTIL recently, sociologists, psychologists, psychoanalysts, and economists have largely ignored the importance of drinking practices and behaviors while drinking for understanding the social and cultural context in which drinking pathologies develop. Thus, behavioral scientists are in the same situation as the psychoanalysts and psychiatrists whose almost exclusive concern with neuroses, psychoses, and other mental disorders allows them to make few generalizations about nonpathological behavior. Thus this paper will be concerned with an international overview of drinking practices and the relationship of these drinking practices to sociological variables of age, sex, social class position, and nationality status. This international overview must of necessity be selective as adequate information and analysis exist for only a few societies, literate or nonliterate, historical or contemporary.



Moreover, each culture reflects a general ethos or feeling tone about the use and role of alcoholic beverages within its social structure. This ethos may also be conceptualized as the cultural attitude toward drinking and drunkenness which exist within any society. Suffice it to say these attitudes run the gamut from absolute prohibition to attitudes of permissiveness.

Our contention is that only by obtaining more research knowledge on specific cultural attitudes toward drinking and drunkenness, and the function and role of drinking in diverse culture will we begin to understand and explain pathological drinking. An approach which begins with a concern with drinking practices would allow one to specify those drinking occasions and situations which fall within a culture's permitted range and those which are deviant and may indicate the beginning of a drinking pathology. Moreover, one must constantly ask how drinking practices relate to other institutional structures of religion, eco-

All cultures can be ranged on a continuum in reference to their attitudes about drinking.

An International Overview

Social and Cultural Factors in Drinking Patterns

BY DAVID J. PITTMAN, Ph.D.

Dr. Pittman is a professor of sociology and director of the Social Science Institute at Washington University, St. Louis, Mo. His article was a distinguished lecture of the 1968 John W. Umstead Series of Distinguished Lectures.

nomics, family, and so forth, within the culture. This approach would allow one to construct for some cultures the social and dietary norms of drinking which are essential for defining the "excessive" component in the World Health Organization Committee of Experts' definition of alcoholism which is:

> Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it results in noticeable mental disturbance, or in an interference with their bodily and mental health, their interpersonal relations, their smooth social and economic functioning or those who show the prodromal signs of such developments.

The general areas discussed in this international overview of drinking practices are relevant to any specific culture. The following basic questions are posed for analysis:

1. What are the cultural attitudes toward drinking?
2. How extensive is the use of alcoholic beverages within the culture?
3. What social and psychological functions does drinking serve both on the individual and societal level?
4. What is the relationship of drinking practices to the sociological variables of age, sex, and social class position?

Theoretically it is possible to range all cultures on a continuum in reference to their attitudes about drinking. At least four cultural positions can be constructed. These are:

1. The cultural attitude is negative and prohibitive toward any type of ingestion of alcoholic beverages. This may be referred to as the *Abstinent Culture.*
2. The cultural attitude toward beverage alcohol usage is one of conflict between co-existing value structures. This may be called the *Ambivalent Culture.*
3. The cultural attitude toward ingesting beverage alcohol is permissive, but negative toward drunkenness and other drinking pathologies. For labeling purpose, we refer to this as the *Permissive Culture.*
4. The cultural attitude is permissive toward drinking, to behaviors which occur when intoxicated, and to drinking pathologies. In one sense, this type, *Dysfunctional,* does not occur completely in societies but only approximations in certain non-literate societies, in those cultures undergoing considerable social change, and those in which there are strong economic vested interests in the production and distribution of alcoholic beverages.

Numerous cultures have as a basic tenet the abstaining from alcoholic beverages. Three broad cultural groupings should be noted—namely people living in the Islam, Hindu, and Ascetic Protestant traditions.

In Islam Mohammed, the Prophet, proclaimed "The use of spirits was prohibited by the Koran," and historically the Islamic tradition has been antagonistic toward drinking in North Africa, the Middle East, and India. Furthermore, Mohammed forbade believers to sell or dispense alcoholic beverages. That some Moslems do drink in these areas is reflective of cultural diffusion of European patterns and the decay of tradition with industrialization and urbanization.

Both custom and tradition in Hindu Indian society established a moral standard which negatively evaluated the drinking of alcoholic beverages. For example, the Indian law giver, Manu, classed beverage alcohol drinking as one of the greatest anti-social acts or sins and suggested abstention. The principle of total abstinence and Prohibition is reflected in the Indian Constitution (Part IV, Article 47), written after inde-

pendence was achieved from Great Britain. The article in part states:

> . . . and in particular, the state shall endeavor to bring about prohibition of consumption, except for medical purposes, of intoxicating drinks and drugs which are injurious to health.

Thus all Indian states are to work toward Prohibition in accord with the Constitutional Provision. Thus far, not all Indian states have complied with this provision, nor is there any indication that they will.

In Western culture, particularly in Northern and Western Europe and the United States, historically the emergence of all powerful temperance movements, especially during the nineteenth century and the early part of the twentieth century, has been intimately related to ascetic Protestantism. For example, the first recorded total abstinence pledge in Great Britian was taken by a clergyman, the Reverend Robert Bolton in 1637. In 1809 an Anglican minister, Reverend Cowherd, converted to the Swendenborg Doctrine, made total abstinence a prerequisite for membership in his Bible Christian Church in Salford, England. His disciples and other temperance leaders in Western culture saw in the drinking of spirits the cause of the social evils concomitant with Industrial Revolution. These early reform movements were geared toward moderate drinking, not total abstinence.

In the United States and Great Britain, the total abstinence position captured the temperance movement. In the United States the rise to dominance of the abstinence and Prohibition orientation was intimately related to the ascendance of the middle class, who viewed sobriety as a necessary trait for achievement and success in the emerging capitalistic economic system. Abstinence formed a part of a larger value structure of ascetic Protestantism which was hostile to expressions of emotional impulses. Thus in many Protestant groupings there was a prohibition not only on drinking but upon dancing, use of tobacco, recreation on Sunday, and use of cosmetics.

In part of Northern and Western Europe, however, some temperance movements have concentrated more on what the word temperance actually means, i.e., the use of alcoholic beverages in moderate amounts or the non-usage of spirits with moderate consumption of beer and wines. In the United States, the distinction between temperance and abstinence has been lost and the terms, unfortunately, are used synonymously.

The emphasis on abstinence and temperance in Western Culture must however be viewed as a social movement which attempted to cope with the problems of the Industrial Revolution and urbanization. In ascetic Protestant beliefs an attempt was made to apply the Christian principles to the everyday world of the workman. In the nineteenth century in England the consumption of spirits increased rapidly, and the new factory occupations encouraged drinking among the workmen. The reformers in their naive belief that drinking and drunkenness were the keys to social disorganization and personal pathologies of the Industrial Revolution were relatively unconcerned with its social causes.

The abstinent subcultures are still in existence today in large parts of Finland, Sweden, Norway, Great Britain, Canada, and the United States, and in the religious groups of the Christian Scientists, Mormons, Seventh Day Adventists, Pentecostal churches, and some Baptists and Methodist groups.

In cultures marked by ambivalence toward beverage alcohol usage, there

is conflict between co-existing value structures such as in the United States or Ireland. In some non-Western primitive societies or among the American Indians, traditional values are in the process of change or disintegration due to cultural contact with other societies. Examples of societies whose rate of cultural change is so rapid that stable attitudes toward beverage alcohol are disintegrating are found in certain Polynesian societies, studied by Lemert, and the Agringados, Mexican-Americans, found in South Texas, who are rejecting the Mexican-American way of life and have begun to identify with the American culture. Another type of ambivalence as noted by Krauweel in the Netherlands is that some societies accept drinking but reject the drinker who becomes an alcoholic.

Probably in American society one finds the prototype of the ambivalent culture. The American cultural attitudes toward drinking are far from being uniform and "social ambivalence" is reinforced by the conflict between the drinking and abstinent sentiments co-existing in many communities. Strains toward drinking are found in certain religious groups whose ceremonies include the use of alcohol (e.g. Jews), persons who have traditionally regarded the use of liquor as the appropriate means of expressing hospitality and sociability (e.g. Irish-Catholics), and, of course, the liquor industry. Abstinent groups are characteristically composed of ascetic Protestant groups who believe the use of alcohol is sinful and who therefore see little difference between the occasional social drinker and the chronic inebriate, since the former is the beginning stage for the latter.

Drinking pathologies in American society are perpetuated by cultural attitudes that veer toward asceticism and hedonism. Myerson has used the phrase, "social ambivalence," in reference to American cultural attitudes toward drinking. It is his position that this ambivalence limits the development of stable attitudes toward drinking that are found in certain other cultures; moreover, it restricts the meaning of drinking to one of hedonism and insulates drinking practices from social controls. Thus, drinking becomes an extreme and uncontrolled form of behavior for many. Some verification is found for this position in Skolnick's study, which finds more alcoholic complications in groups of students from abstinent backgrounds. He states:

> Total abstinence teaching which impounds and implants a repugnance to drinking and inebriety tends to identify the act of drinking with personal and social disorganization. Thus, it inadvertently suggests an inebriety pattern for drinking and encourages behavior it most deplores.

In this statement Skolnick is suggesting that individuals who become alienated from their abstinence backgrounds may use excessive drinking as a means to act out their frustrations against early family, religious, and community teachings about drinking. In this situation, problem drinking, viewed against a background of total abstinence, becomes a symbol of revolt and attempted escape from early inculcated values.

Another culture with ambivalent attitudes toward drinking is that of the Irish. The Irish male's drinking is dissociated from the network of religious ideas and, furthermore, is not part of the family's usual social routines. Some of the drinking is convivial in nature. As Bales indicated:

> . . . drinking together is a symbolic . . . manifestation of the solidarity of "friends" or kinship groups, of the acceptance of the individual male as a "man among men," as an equal in his

> own . . . age group; drinking together is a manifestation of the equality and solidarity of town and country folk, of the guest and host, the politician and his constituents, the seller and buyer.

But Irish drinking is also utilitarian in the sense that the anesthetic effects of alcohol provide a means of handling psychological tensions. Given the fact that Ireland has the latest age at first marriage for males (around 35) in the world, drinking by males serves to reduce sexual tension and familial conflicts.

Permissive cultures are those in which the prevailing attitude is positive toward the use of alcoholic beverages but there may be attitudes, as among the Jews, which proscribe drunkenness. Examples are found in Spain, Portugal, Italy, and among New York's Chinese and in the Jewish religious group.

Both Snyder and Lolli have reported that Jews and Italians are almost universally exposed to alcohol beverage usage. One survey for example, reported that 87 per cent of the Jews were users of alcoholic beverages. But alcoholism rates among the Jewish and Italian ethnic groups are low in comparison to those among Irish and Scandinavian groups. However, the problem of alcoholism has been increasing significantly in Northern Italy, especially in the Milan-Turin area in the last decade.

The crucial fact in explaining low alcoholism pathology among the Jews is based upon more than their permissive attitudes toward drinking. Snyder has indicated in traditional Judaism drinking is integrated into the "traditional rituals of the annual cycle of holy days and festivals, the *rites de passage,* and the observance of Sabbath." Furthermore, drinking is learned in a highly controlled ritualized manner within the family context. Drunkenness is negatively evaluated and sobriety is viewed as a Jewish virtue.

Permissiveness toward use of alcoholic beverages is a characteristic feature of Italian culture where, according to Sadoun and Lolli, such protective features as "early exposure to dilute alcoholic beverages" within the family, parental acceptance of moderate drinking, and the "use of alcohol as a food to be taken in moderation with meals" occurs.

As noted before, this is an extreme or polar type of cultural attitude which exists only in part, never in entirety. The attitude toward drinking, to behaviors which occur when intoxicated, and to drinking pathologies is permissive.

A partial representation of this cultural attitude is found in Japanese culture. Drinking of sake, a rice wine, and beer is widespread, and the act of drinking has many traditional and ritualistic meanings. The traditional attitude of tolerance toward the drinker reflected in excusing him and blaming alcohol for his misbehavior has been partially replaced by a harsher one.

In the Camba society, located in Eastern Bolivia in South America, on festive occasions the population drink a highly concentrated alcoholic beverage, and drunkenness becomes a norm and a part of the social ritual. As Heath has noted:

> Drunkenness is consciously sought as an end in itself, and consensus supports its value. Aggression and sexual license are conspicuously absent on those sole occasions when beverage alcohol is used. Moreover there is no evidence whatsoever of individual instances of dependence upon alcohol comparable to alcoholism or addiction as it is known in the United States.

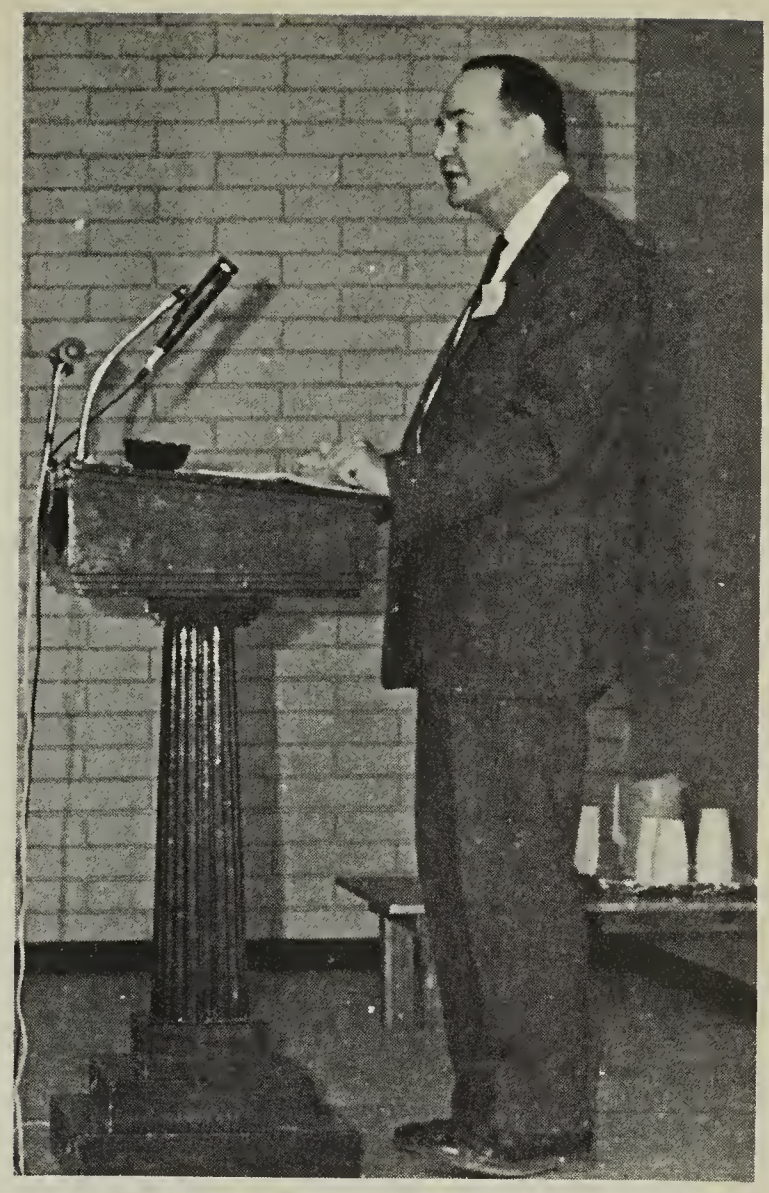
The problem of classifying the cultural attitude in France is a complex one. There is no doubt about the fact that the attitude toward drinking

(Continued on page 31)

BIOLOGIC AND ADDICTIVE ASPECTS OF ALCOHOLISM

BY PETER N. WITT, M.D.

Biological roots of addiction are seen in the phenomenon of adaptation in nature and in genetic coding.



ONE way of improving our understanding of alcoholism is to look at its place in a wider framework. I propose to look at alcoholism as a specific case of drug addiction.

Alcohol is a drug like morphine or cocaine, peculiar in some ways, similar in others. Alcoholism shows all the characteristic properties of drug addiction. One can learn about it by reviewing the strange phenomenon that a human being can become dependent on the intake of a chemical substance, can commit an anti-social, criminal act to obtain the substance, can regard the drug as the most important part of his life, both an angel and a devil, to be praised and cursed, but hardly able to exist without.

Man and his reaction to drugs can be regarded from many different angles. For the purpose of understanding, one has to look at these angles separately—look at man as a biochemical machine, a physiological organism, an individual who behaves in reaction to surroundings according to inherited and acquired guidelines, a social and a religious one. In stressing the biological angle of man's addiction, it is assumed that everybody realizes that this is only one of many viewpoints.

One of the puzzling aspects of addiction is its compulsive nature: the addict has to take the drug again and again, increasingly threatened by the appearance of frightening withdrawal symptoms as soon as he is without drugs. Addicts frequently compare the way they feel in the absence of the drug with hunger; it feels "as if something were missing." "I feel normal after my injection, sick only without it," can be heard frequently. Sudden withholding of the drug can cause severe circulatory

This article was a distinguished lecture of the fifth annual John W. Umstead Series of Distinguished Lectures held in Raleigh in February of 1968. Dr. Witt is director of the Division on Research of the N. C. Department of Mental Health.

and autonomic nervous symptons, fall of blood pressure, change of heart rate, shallow respiration, goose pimples, diarrhea, etc. The withdrawn addict lies for several days moaning under his blanket, unhappy, depressed, weak.

On the other hand, the achievement of "normality" under drugs frequently requires the taking of increasing doses. De Quincy in "Confession of an Opium Eater" tells us that he finally had to take 133 drachms (about 300 times the therapeutic dose). In order to feel "normal" and comfortable an addict has to take an amount of the substance that would kill the unaccustomed. Do we know something more about this? Can we understand it better as a general biological phenomenon, or is this only the manifestation of an individual's mad search for pleasure?

A look at the phenomenon of adaptation in nature appears to be helpful. Adaptation is built into all living beings. It can be studied at any level of organization and is easiest to study at the level of animals with one cell.

Dr. Phillip B. Dunham, a biochemically oriented zoologist at Syracuse University, New York, observed such mono-cellular organisms in their normal surroundings, namely in tap water. The animals swam around, ate, propagated, and showed all the signs of healthy behavior. He then added some sodium chloride to the water in increasing amounts every day. As long as he kept the daily increase small, these animals lived "happily" in a 200 mm sodium chloride solution, the same solution which would have killed them if they had been put into it at the beginning. Another experiment showed that the little animals were no longer the same; when he transferred some individuals back into clear water they burst immediately and died. Only a gradual, slow reversion to original living conditions permitted the animals to survive.

Dr. Dunham, in trying to find out what the difference between the adapted and unadapted animals was, went a step further in his investigation. The normal animal of this kind tries to preserve a steady concentration of 12 mg per cent sodium on the inside. It achieves this with the help of a pumping mechanism with which it eliminates excess sodium or lets sodium in from the environment. The cells brought into the high sodium concentration at first accumulated much more sodium inside—105 mg per cent instead of 12 mg per cent. But soon their pump began to work faster, and the sodium concentration was brought back near control levels (to 21 mg per cent). This new level of pump activity could no longer be reduced on short notice, and the cell brought into the original medium died from lack of sodium inside. Only gradual reduction of sodium concentration outside permitted the pump to reduce its speed. The cell had adjusted to cope with the high sodium outside in the course of several weeks, and was unable to stand sudden reduction. I leave it to you to draw a parallel between these observations and the phenomena of tolerance and withdrawal symptoms in the addict who is, after all, another biological system in a chemically changed environment.

From the first model, the compulsiveness of the process becomes understandable. Whether there is much pleasure involved in obtaining the effect of the drug seems, at least at the later stage of addiction and after the development of tolerance, quite irrevelant. The fact that some drugs which cause a most interesting and frequently enjoyable experience like

mescaline (from cacti) or psilocybin (from mushrooms) are not liable to produce addiction while others show a high addiction liability should have already made us cautious toward the conclusion that the individual seeks pleasure through repeated drug administration. It can be experimentally established that some drugs possess *a priori* a high addiction liability and others do not. What makes a drug this way is not known. Could it be that addicting drugs stimulate a certain area in the central nervous system, and that this area has to be stimulated again and again to obtain satisfaction, establishing a vicious circle, once the process has started? Experiments of James and Marianne Olds in Michigan seem to pinpoint such a center.

Experiments Conducted

These experiments managed to implant in a number of rats two electrodes in different areas of the brain. Each pair of electrodes was connected by means of wires to an electronic stimulation device above the cage, the wires being designed in a way which did not restrain the animals in their movements. The Olds' built a lever into the circuit which could be pressed by the rat; each pressing would release a series of small electric stimuli of one half second duration. If the lever was held down, or if it was released and not pressed again, no stimulation would occur. The experimenters wanted to find out whether such stimuli would be perceived and manipulated by rats in a way that would reduce stimulus frequency to a low level. A recording device indicated the amount of stimulation that the rat had produced over a certain period of time.

The surprising discovery, which has since been confirmed by many investigators, was that when the electrodes were placed in such a way that certain areas in the forebrain system were stimulated, the animal quickly learned to press the lever very frequently. Rates (in eight minutes) ranged from 600 up to 1200 responses and higher. All other areas showed the rats either carefully avoiding restimulation after one effort, or the animals were indifferent.

To clarify further the nature of this effect, Olds and Olds compared the rewarding nature of the stimuli with those of eating in hungry animals. Instead of food as reward, self-stimulation was used to cause organization of a complicated response pattern like learning to run through a maze. When two groups of rats were compared, one receiving food as reward for crossing the maze and the other receiving self-stimulation, both learned equally fast to reduce mistakes. However, the stimulation group ran faster for the reward than the hunger group. When, after four days of training, the stimulation reward was withdrawn, extinction of the acquired response appeared with the same speed for both groups in about four days. These observations appear particularly interesting in the light of the frequently quoted remark by addicts that drug withdrawal is like getting hungry, and the drug makes them feel satiated. But notice that in these experiments no drugs were involved.

Let us return to drugs, but stay with our animal models for the purpose of obtaining further insight into the self medication and regulation of dosage. The experiments to be described in the following were carried out by J. R. Weeks in rats and monkeys. They chose settings in which rats could take the drug at will, regarding this as a model relatively close to the human addict.

(Continued on page 18)

Is there a better way to get alcoholism services to the people in its region, asks this program, unique in North Carolina?

South Central

BY WILLIAM HALES, M.P.H.
SOUTH CENTRAL REGIONAL
ALCOHOLISM PROGRAM DIRECTOR

THE function of the North Carolina Department of Mental Health is to provide or to insure provision of services to the citizens through its program components of which the program of alcoholism is no exception. To more effectivly augment the delivery of mental health services, the department has divided the state into four mental health regions, each served by a state hospital, and 37 mental health areas. This report will generally concern itself only with the South Central Region, and more specifically with the development of a regional alcoholism program. This program will be administratively attached to Dorothea Dix Hospital which serves the twenty-two counties and nine mental health areas which geographically make up the South Central Region of North Carolina. Dix is the only state institution in the region currently admitting alcoholic patients and does offer a seven day detoxication service followed by a voluntary three-week program which includes patient government and some types of group therapy.

As a result of legislation passed in 1967, two new alcoholic rehabilitation centers were constructed—one in Greenville, N. C., to serve the Eastern Region, and one in Black Mountain to serve the Western Region. The existing center at Butner was replaced with totally new facilities and serves the North Central Region. This left only the South Central Region without an ARC. The 1969 General Assembly made funds available for an ARC for this region. Rather than expand bed capacity through the construction of an ARC, Dr. Nicholas E. Stratas, deputy commissioner for the South Central Region of the Department of Mental Health and Dr. Robert Rollins, associate regional deputy director and superintendent of Dorothea Dix Hospital, requested and received permission to use these funds to implement a total regional effort to work with the nine community mental health centers in the development of a more comprehensive alcoholism program with the emphases on local or community administration and participation. It is envisioned that this type of programming will be more effective in delivering the following alcoholism services to the 1.5 million people in the South Central Region of North Carolina:

(1) A more complete continuity of care for a person with alcoholism;

(2) Better techniques of early detection and case finding;

(3) Provision for local treatment and rehabilitation that involves not only the individual, but the family and possibly the employer;

(4) Follow-up and/or aftercare;

(5) More adequate educational programs directed toward: a) schools or persons of school age; b) those who professionally (socially workers, lawyers, law enforcement officers, etc.) come in contact with the problems of alcoholism and; c) the general public on the nature of the illness of alcoholism; and

(6) Continuing evaluation and re-

egional Alcoholism Program

search activities.

The nine mental health centers are currently doing an outstanding job of providing mental health services to the people of their area and are serving as liaison between the community and Dorothea Dix Hospital. In the field of alcoholism, they are operating various types of programs with each providing somewhat of a different emphasis. The regional concept will not only render assistance to their current individual program efforts, but will coordinate the planning, development, maintenance, and improvement of a comprehensive program for the prevention, treatment, control and research in the area of alcoholism.

"No community has yet developed a comprehensive range of services; on the other hand, the total amount of services provided persons with problems of alcoholism in their family has increased greatly during the past several years. For example, in the year 1962-1963, 1,444 patients with a diagnosis of alcoholism were admitted to the four North Carolina state hospitals. In 1967-1968, there were 4,006 admissions. The funding of community alcoholism has increased from approximately $50,500.00 in 1962-63 to approximately $300,000.00 in 1967-68. The total alcoholism budget has increased approximately from $750,000.00 in 1962-63 to approximately $3,800,000.00 in 1967-68."* With this in mind and because of the physical, psychological, emotional ,and social problems surrounding alcoholism and alcohol related problems, the South Central Region is currently involved in an indepth study of the present system of operation to determine possible alternative courses of action. This study will have these phases:

(1) A conceptual analysis of the social problems of alcoholism as it exists within the region and state.

(2) Identification of problem areas (jails, local hospitals, courts, etc.) and how communities respond. How is alcoholism defined and by whom and what is currently available to deal with the problem.

(3) The establishment of meaningful goals and feasible alternatives for reaching such goals.

(4) Testing and evaluating implemented alternatives.

This study is being conducted by resource persons from the Research Triangle Institute and from North Carolina State University on a con-

* Alcoholism Programs in North Carolina, Osberg and Blackley.

(Continued on page 20)

BIOLOGIC AND ADDICTIVE

CONTINUED FROM PAGE 15

For the purpose of their investigation a tube was positioned in the rat's heart and connected to a syringe. The syringe, outside the cage, was pushed forward by a motor to inject a measured standard amount of fluid as soon as the rat pressed the lever. In the beginning of the experiment, the rat received a shot of morphine every hour for two days, starting with 2 mg and building up to 40 mg per kg. At the end of the second day the mechanism was adjusted so that the rat could inject itself with a 10 mg dose of morphine each time it pressed the switch. Most rats stabilized thereafter at one injection every two hours—some a little more frequently, some less. They were apparently able to gauge the desired dose.

The next step in the experiment was taken to find out how well the rat would be able to adjust the dose if conditions were changed. Instead of 10 mg/kg morphine per injection, the solution was diluted to deliver 3.2 mg/kg each time the lever was pressed. In a few trials the rats established a new rhythm, injecting themselves now about twice as frequently as before. If morphine was further reduced, injections grew even more frequent. And leaving out morphine from the solution altogether, a high frequency injection pattern was followed by slowing down to almost cessation of lever pressing. All abstinence symptoms could be observed in the rats, and the symptoms could be promptly relieved by a single injection of morphine.

The mechanism could be programmed to inject a single dose of morphine only after ten lever pressings. The rats reacted with keeping quiescent in the intervals and pressing 10 times in a row at the end of two hours, so that the original dose per time was received—indicating again the ability to titrate the optimal amount. Replacement of morphine with other addicting drugs showed the same pattern of response.

A last set of animal experiments should be discussed now because they shed light on the role of differences in different individuals. On closer observation it becomes apparent that some persons do not become addicted to drugs in spite of extensive exposure, while others seem to seek out the places and surroundings where drugs can be obtained and are used. It is very difficult to separate the role of the early experience of a person from that of his inherited traits. Though it seems likely that addiction in parents makes children more susceptible to similar behavior, we hardly know how much of this is due to early influences and how much is inescapably anchored in the genes. Another question that the following experiments try to answer is that of the choice of drugs. Can a certain person or personality become addicted only to a certain drug, or is drug selection a question of more or less accidental exposure?

Just last year two investigators, Nichols and Hsiao, published the results of a series of experiments in *Science* which, I believe, shed some light on these questions. They caged rats individually and offered two calibrated 100 ml drinking tubes—one with tap water and one with 0.5 mg morphine per ml water. Rats automatically preferred the water and never touched the morphine solution, even after they had been injected with morphine once per day in the amount of 10 mg/kg for 17 successive days. However, if the rats were deprived of water for 24 hours,

then received only morphine solution to drink for 24 hours, then they got tap water for another 24 hours, and if this was repeated 5 times for altogether 15 days, they preferred the morphine solution to water. When the morphine solution was withdrawn, three days of severe withdrawal symptoms appeared; 12 days later animals were close to normal and no longer showed signs of physical dependence. At this time rats were brought into the original situation in single cages with tubes of 100 ml drinking water and 100 ml morphine solution to choose from. Soon some animals now drank regularly large amounts of morphine solution, while others drank little and preferred water.

After morphine preference had been established as a stable trait in certain individuals, the rats were separated into two groups—those that would prefer morphine over water and those that would rather drink large amounts of water. Animals in the middle range—which drank equally from both solutions—were eliminated. The morphine-drinking rats were now bred to each other and the water drinkers were also bred to each other. The morphine preference of the offspring was then tested. This procedure was followed through four generations. It could be established that the morphine preference increased from generation to generation in the one group and decreased in the other. The difference from generation to generation was increasing significantly below the 0.005 probability level.

After having established this preference pattern in the animals, the authors asked the question whether the preference of morphine over water was specific for morphine in each strain or whether it was a rather general drug preference. Again two strains of rats were used which had now been bred for four generations and they were tested for their preference for alcohol in water or clear water. It was again necessary to proceed through five periods of alcohol exposure in the way described above; one day of complete withdrawal of drink, one day of exclusive exposure to alcohol water, and one day exposure to tap water. At the end of this period the rats were again given a choice between the alcohol + water and clear water. It may be useful to remember at this point that previously rats would not have drunk water with alcohol at all; they apparently found this quite distasteful. It became quite clear that the morphine rats now became addicted to alcohol. After successful withdrawal, the morphine susceptible strain of rats drank twice as much alcohol as the other strain (24 vs 12 ml), and this difference was significant at the 0.005 probability level. Non-addictive drugs were not found to be preferred over water by any of the animals.

It is time to summarize what we have learned from the animal experiments. Let me repeat that we have only touched on a small sector of the problems which are related to drug addiction. No mention has been made of the preference for certain drugs in certain parts of the world: alcohol in the West and opium in the East. Little has been said about personality traits of the addict, his early experience, the exposure and opportunity to obtain the drug, his mental and physical health. We have also taken the liberty of lumping drug addiction together into one big category in spite of the fact that we know very well that one drug may stimulate the addict, another may make him sleepy, another —like alcohol—acts first one way

and then the other. This was done to draw a more general picture of the biological roots of addiction, certainly a simplified one, but one which is important and impressive.

All experiments have clearly indicated the compulsive nature of drug addiction at the cellular level, in brain stimulation, or in self medication. Once started, the deviation, or adaptation, grows according to its own laws. The development of tolerance, or adaptation, and the causally related withdrawal symptoms force the addict to continue drug self medication with increasing doses. For some unknown reason tolerance to the undesirable effects of the drug frequently develops not at the same rate as tolerance to its desired effect, and the addict gets increasingly uncomfortable. Once "hooked," he looks no longer for a pleasurable experience or "the shortest way to paradise on earth," he just wants to feel—in his own words—"normal." Independent of whether we attribute freedom of will and moral responsibility to man, the observation that an animal can be bred to high or low drug preference is a biological argument in favor of regarding the addict as a person severely afflicted, rather than as somebody with evil designs.

But in reading newspaper articles and even some of the professional journals, one cannot help getting the impression that addicts are sometimes considered as people who have only to be severely reprimanded or even threatened with punishment and they will pull themselves together and break the habit. The deep roots of addiction in biological properties of adaptation and in genetic coding contradicts the reasonableness of such an attitude.

The results of the experiments just quoted together with much other evidence seem to me to teach us another lesson: to put all the blame on the drug appears to be too easy a way out. Remember the rats which became "addicted" to an electrical stimulus in the brain and preferred this as a reward over food? Remember the animals which showed high morphine preference but then manifested a similar preference for alcohol? I propose that we regard the drug as only an instrument; it can be used in many ways, skillful or clumsy, for good or bad, depending on the hands of the user. The instrument can easily be exchanged, but it is the guiding hand that makes it useful or damaging. Biological thinking warns us not to get too satisfied with pointing to alcohol, morphine, or LSD as the source of trouble. We should rather treat sick individuals and a sick society if they are found to misuse a drug.

SOUTH CENTRAL REGION

CONTINUED FROM PAGE 17

tractual basis and is under the direction of Harold Holder, Ph.D. from the Department of Mental Health. The program planning and implementation will be determined by a regional team, consisting of representatives from each of the nine mental health areas, the regional director and staff from Dorothea Dix Hospital, with consultation from the Department of Mental Health and the above resource persons.

As a summary, the South Central Regional Alcoholism Program, through an application of systems analysis, is to look at alcoholism and alcohol related problems of the region to determine if existing methods are inadequate. If so, what alternatives are there, how can they best be implemented, and what would they cost, and what are their predictable consequences.

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Public intoxication statutes reflect a concern not about drunkenness, but rather incapacity to live.

Law and Alcoholism

BY JUDGE JOHN M. MURTAGH

THIS morning I am going to try to express as briefly as I can, my thoughts on the subject of alcoholism and the law. It is particularly pleasant to talk here in North Carolina in that a real breakthrough in traditional legal thinking has come about in the last year or two, thanks in large measure to the circuit court of appeals for the fourth circuit which presides here in North Carolina. Needless to say, to those of you who are members of the Bar, I refer to the outstanding case of Driver versus Hinnant.

Most of us who are interested in the field of alcoholism understandably rejoice in both the Driver Case and what is referred to as the Easter Case. They are landmarks and their great contribution is that they have refused to accept the traditional, have challenged it and called for a new day. Personally I rejoice in the reversal of the convictions in these cases, but I dissent from the rationale of the opinions. I call for a much more sweeping denunciation of the traditional than is reflected in either the Driver or the Easter Cases.

Now what am I talking about? Let's go back momentarily to New York City. I have been looking at the scene that is reflected in these two cases since 1950. When I went into the court first and saw the traditional group of drunken derelicts paraded before the bench, instinctively I felt that this drama was tragic and, more important, it reflected the ignorance, the inadequacy of society itself. One would not have had to be very perceptive to recognize that the police and the judicial approach to the unfortunate and inadequate souls that frequent our skid rows was anything but effective or justified.

In New York City in those days, the drunks were paraded before the bench on a charge of disorderly conduct in that allegedly being "under the weather," being drunk and disorderly and disturbing the peace, causing a crowd to collect, they violated Section 722, Subdivision 2 of

This article is a distinguished lecture of the fifth annual John W. Umstead Series of Distinguished Lectures held in Raleigh in February of 1968 under the auspices of the N. C. Department of Mental Health. The Honorable John M. Murtagh is a Justice of the Supreme Court of the State of New York.

the New York State Penal Law.

Those of us who are lawyers would recognize almost immediately that the charge was a little dubious. We know—whether we are in North Carolina or in any other state of the union—that disorderly conduct requires some sort of disturbance of community peace and well-being; that if one is a mere nuisance he doesn't qualify for a conviction of disorderly conduct. If I don't like you, if the community doesn't like you, you're still not disorderly. You achieve that status only when you punch someone in the eye or you make so much noise or commotion that you are disturbing the order, the well-being of the community. That is the essence of disorderly conduct.

But I found that the derelict invariably pleaded guilty. We assumed authority. We put them in jail for a period of time or we gave them a suspended sentence. This of course did not appeal to me as justice and, somewhat naively for a period of time, we embarked on various so-called rehabilitation programs to make meaningful the efforts of the City of New York. None of them were ever too successful and for one reason or another they fell by the board.

I continued to be intrigued by the problem of skid row. I became curious about another problem that I assumed was involved (I'm not so sure today), the problem of alcoholism, to the end that I went up to Yale. In those days Yale University had its School of Alcohol Studies; I subjected myself to thirty days of postgraduate study. Indeed, ever since, it has been my boast that I got my law at Harvard and my alcohol at Yale. It was an interesting experience. The faculty was excellent; it approached this enigmatic problem from all of the disciplines

There were no arrests in New

in a very balanced, scientific fashion.

When I had finished this course, of course, I was an expert on alcoholism. I haven't yet met an expert in the field, but I was then an expert, and the following winter one of my classmates at the University of Syracuse in New York, conducted a series of lectures on the subject of alcoholism. I was invited up to give the talk on law and alcoholism, much as I am giving it here today. This was back around '54 and, of course, I deplored the arrest of drunks in New York on a charge of disorderly conduct. I pointed out, much as I have this morning, that my conscience was disturbed, that I felt that the bulk of the defendants were not guilty of disorderly conduct and that we as judges almost had a moral obligation to refuse to accept a plea of guilty; that we should rather put the police officer to his proof and dismiss the charge. When I was finished, much as this morning, I was subjected to a question and answer period and in the audience, unfortunately, was a member of the Bar. He raised the question as to why, if I were dissatisfied with arrests for disorderly conduct, we didn't use the public intoxication statute.

Truthfully, I had never heard of such a statute. I did a litle double talk and then I went to New York City and I looked up the law. I found that the Penal Law did have a staute that read Public Intoxication and provided for the arrest of these fellows for nothing more than being drunk in public. A little to my consolation the last paragraph provided that it applied to the entire state with the exception of the five counties of the City of New York. I

thought that therein lay justification for my ignorance. I was, however, disillusioned about a year later when, going through the New York City Criminal Courts Act, I found that there was such a statute there and indeed that was the reason for the exception in the Penal Law. We had one in New York City long before the Penal Law.

Then I was really baffled, but research, I think, gave me the answer. Back around 1936 we had a magistrate, Frank Oliver. He was a sound lawyer, but more than that, a perceptive human being. Many of his rulings in those days read like the Supreme Court of the United States in the 1960's. He was constantly sensitive to police oppression. He was a civil libertarian in the best sense of the word. One day he had a drunken derelict before him. He looked down at the complaint. The charge was public intoxication. The defendant was allegedly under the weather and allegedly had been lying on the sidewalk. Judge Oliver took the initiative, made a motion himself to dismiss the complaint as insufficient and granted his own motion. When I came across this bit of wisdom, I thought the old judge was confused again. In New York in those days many thought that he was a bit of an eccentric and I hadn't matured sufficiently to differentiate between wisdom and eccentricity and so I, too, felt that he was eccentric at that time. He said, in effect, that the charge didn't lie unless the public drunk was disturbing others. I reread the statute and it said nothing about disturbing others and I assumed, somewhat superficially, that the judge had misread the statute, had confused it with disorderly conduct.

Now—without going into that at the moment any more fully—let me say that four years later the then mayor appointed another chief magistrate, Henry Curran by name, who probably was the only one on the landscape who agreed with Oliver. He agreed sufficiently that with his administrative authority he directed the clerks of court to send to headquarters all forms dealing with public intoxification and when they got back he directed that they be destroyed. There followed a period from 1940 on when the police, through this administrative technique, were stopped from using the public intoxication statute. Therein lay the only justification for my ignorance. The law was on the books, but, thanks to Henry Curran and Frank Oliver, there was a period from 1940 through 1962 when not a single arrest was made under the statute and it stemmed from this thought—that being drunk in public did not constitute a crime *unless the community was being disturbed.* Now what happened was that a somewhat lesser number of arrests continued to be made, but only under the disorderly conduct statute. This is what confronted me in 1950.

I then was convinced, of course, more than ever that our approach was wrong, that we should be challenging the police in making these arrests, but one judge or a group of judges hesitates, understandably, to break tradition and fight constituted authority itself, in the form of the police, lest it be regarded as the act of a maverick. So nothing much happened for some years.

In 1962 I wrote an article on this

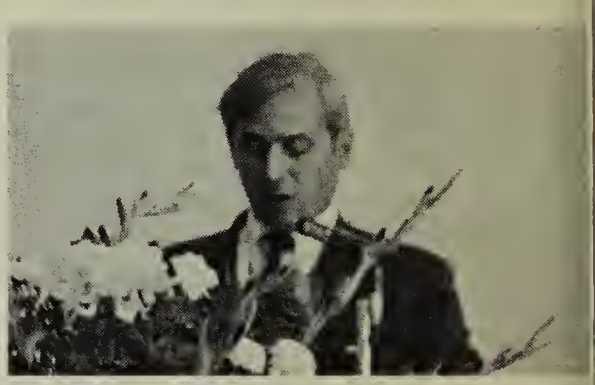
(Continued on page 26)

What's brewing?

A feature designed to keep you posted on programs and events in North Carolina.

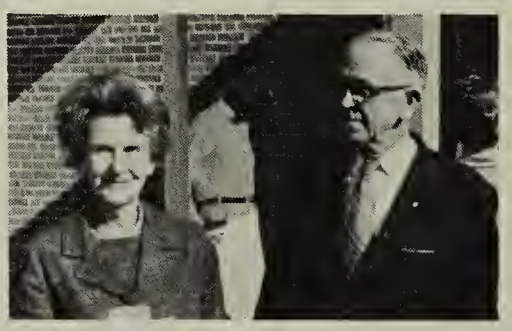
Highlights... ARC Dedication at Butner

Members of the Board of Mental Health and Department of Mental Health officiated at the dedication ceremonies. Former Gov. Dan Moore was introduced by J. Garner Bagnal (center), member of the board's Alcoholism Committee. Dr. Bruce Whitaker (right), committee member, gave the invocation. Other participants were R. V. Liles, committee chairman, who gave the welcome; R. J. Blackley, M.D., deputy commissioner on alcoholism, who introduced the scientific speaker; and Edward L. Rankin, Jr., chairman of the board, who presided.



This series of pictures (left to right) shows Dr. Thomas Plaut, scientific speaker; former Gov. Dan Moore, dedication speaker; and Peter Holden, M.D., who "accepted" the center.

Below (left to right) are: Dr. Bruce Whitaker, who gave the welcome at the Black Mountain ARC dedication; J. Garner Bagnal, who introduced Lt. Governor H. Pat Taylor (next), who made the dedicatory address; and Dr. James Spencer, who made the "acceptance" speech. In addition, Edward L. Rankin, Jr., board chairman, presided and Rev. L. B. Laye gave the invocation.



R. V. Liles, Alcoholism Committee chairman, and Mrs. Liles.

Highlights... ARC Dedication at Black Mountain

Members of the Executive Committee of the Alcoholism Programs of North Carolina are from left to right above: Lantz Sykes, Greensboro, vice president; Ben Garner, Jamestown, president; Donald Dawson, Washington, treasurer; and Bill Hales, immediate past president. Other members (not shown) are: Mrs. Olga Davis, Durham, secretary; Mrs. Helen Barrett, Greenville, member-at-large; and ex-officio members, Dr. Norbert L. Kelly and Dr. R. J. Blackley of the Department of Mental Health.

WRIGHTSVILLE BEACH, N. C.: Norbert L. Kelly, Ph.D., director of the Division on Education of the Department of Mental Health, and Worth Williams, director of the Greensboro Council on Alcoholism, were recipients of the first "Distinguished Service Award" presented by the APNC at its recent fall meeting. The award was instigated to honor the North Carolina citizen who has made the "greatest contribution to the control of alcoholism and alcohol problems over a period of years." The Awards Committee, chaired by Marshall Abee of Greensboro, appealed to the APNC for nominees—which resulted in a tie and two "first" awards. The inscriptions on the certificates were derived from the reasons given by the members for their nomination of the recipients. They read:

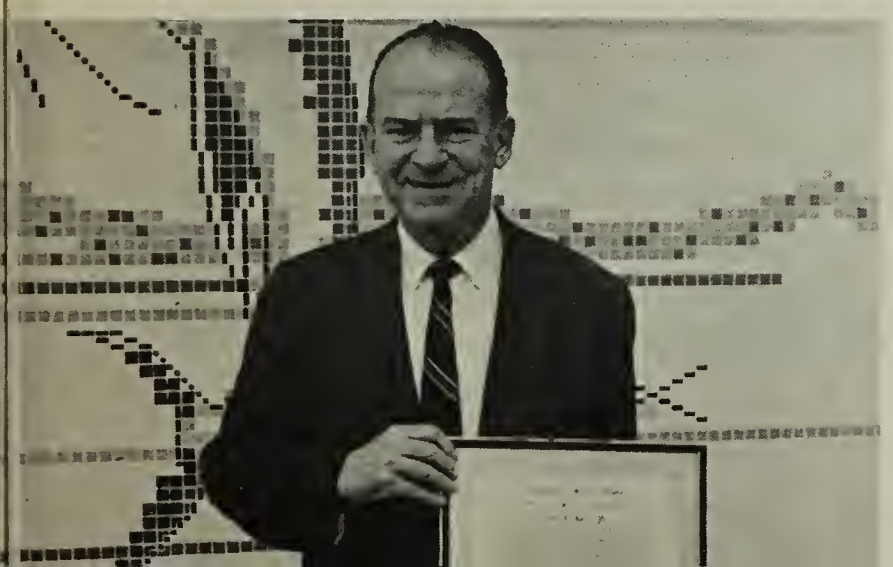
Norbert L. Kelly, Ph.D.

"Dr. Norbert L. Kelly, more so than any other single individual in North Carolina, is deserving of recognition for his many years of dedicated service in, and contributions to, the total field of alcoholism—education, treatment, rehabilitation, research and prevention. All disciplines and professional and lay groups throughout the State have listened to, and benefited from, his teaching, his counsel and his warm friendship. He has also made significant contributions to the development and growth of summer schools, alcoholism programs and public understanding of the alcoholic as a person who can helped and is worthy of help. No one statewide, in our view, has done so much, meant so much, organized and guided so much as our own 'Mr. Alcohol Education.'"

Worth Williams

"For seventeen years Worth Williams has devotedly and unselfishly given himself in service to the cause of helping 'drunks' and fighting alcoholism—at the local level and statewide, county by county. His contributions—to alcohol education in the schools, in organizing information centers, to chronic drunkenness offenders, to youthful first offenders, in legislation and in program development—are significant achievements. But, greater than that, he taught us the 'heart of the matter'—how to fight, what to fight for and to never give up! Whether successful or not, he always 'fought a fair fight' and his motives were aboveboard. His concern for alcoholics was heartfelt and his devotion to the cause of alcoholism genuine."

Given, with deepest appreciation, at Wrightsville Beach this 24th day of October, 1969.



subject for the *Atlantic Monthly*. We had a court reorganization during that year and this necessitated the rewriting of the New York City Criminal Courts Act that contained the Public Intoxication statute which had not been enforced for over two decades. I was part of the official judicial family that communed with the legislature in the revision of that law, and I made bold when an attempt was made to include the section in the new law, to point out that statute had not been used for over twenty years, that it was a dead letter. I stated that I had discussed the subject in the current issue of the *Atlantic Monthly*. I was flattered when the chief judge of the state smiled and said he had just finished reading it and agreed completely. As a result in 1962 the statute was repealed. To give you a complete postscript on the New York situation, the entire Penal Law of the state was revised a year ago. Public intoxication was included back in.

Legal Counsel Provided

The most interesting and significant part of the story, however, relates to the year 1966—my last year in the Criminal Court. The legislature in 1965 provided that in all cases except traffic cases, a judge was required to furnish counsel free of charge to any indigent. I sent out instructions, of course, to my colleagues, that they had to comply and that was in all cases including disorderly conduct. So when the derelicts came, the usual performance was: Do you have a lawyer? No. Can you afford a lawyer? No. Do you wish the court to assign a lawyer free of charge? No. And so for a while there was no change. But I conducted an experiment, I got three or four of my colleagues and I assigned them to the part of court where most of the derelict cases were heard, and I told them to stop the questioning before the last question; merely inquire as to whether they had a lawyer, whether they could afford a lawyer and, if they had no lawyer and they couldn't afford it, to assign a lawyer.

So we had some fifteen hundred cases in which the Legal Aid Society was assigned to defend the drunks and, of course, I talked to their lawyers. They pleaded all of their clients not guilty and there were some fifteen hundred trials. The conviction rate was a relatively small fraction of one per cent. I believe it was seven cases out of that entire lot that resulted in convictions. The remainder were acquitted because the evidence gave no indication that they were disturbing a soul.

With this success I brought to the attention of our clerical staff a requirement that existed in that court, that when an arresting officer or a complainant of any kind gives the clerk who drafts the complaint a state of facts which to his mind does not constitute a crime, he is to refuse to draw a complaint. He is rather to fill out a form and refer the matter to the judge presiding. The judge in turn swears the complainant, in this case the arresting officer, and if he agrees with the clerk he dismisses the charge without a trial. Well, of course, this was magic. All of the cases came in this way, he swore the officer, and out the window they went.

Fortunately, we have a very enlightened police commissioner in New York today, Commissioner Leary. He got wind of what was going on and instead of being resistant, he sent a bulletin to all police commands indicating that there was a change in judicial attitude and suggesting complete compliance there-

with. The result was that there was a full year's time before the new law came into effect in which the arrests in New York City, which traditionally had been somewhat in excess of forty thousand for disorderly conduct, dropped to some ten thousand. There was a reduction of thirty thousand. Now previously I had estimated in writing just this percentage as being the percentage of disorderly conduct arrests that stemmed from the arrests of the drunks. So I can proudly say that temporarily, at least, we brought about a situation in which there was virtually not a single arrest for public intoxication in New York City for an entire year—and yet the city did not collapse.

Driver and Easter Cases

Now this brings me back to an analysis of Driver and Easter. I say most of us agree with it. I don't see how anyone can but agree with the result in both these cases. I think the arrests of derelicts are unconstitutional, but I dissent from the rationale of these two courts (I say two courts; I am referring to the circuit court of appeals for this circuit in the Driver versus Hinnant case; and to the case of DeWitt Easter in the District of Columbia). In both of these cases, the courts ruled that the arrest of a derelict for public intoxication was illegal. Now their analysis was simply this. In recent years the Supreme Court of the United States, by a somewhat circuitous line of reasoning, has applied the so-called Bill of Rights to local communities. It has said in effect that the first eight amendments of our Constitution, known as the Bill of Rights, apply to the states as well as the federal government by virtue of a clause of the Constitution that admittedly applies to the states, the fourteenth amendment. The reasoning of the Supreme Court is that when, in that amendment, the Constitution says that all of the states shall administer due process of law, thereby that magical phrase "due process of law" incorporated either all or a portion of the first eight amendments and made them applicable to the states as well as the federal government. The eighth is one of those Bill of Rights, the eighth amendment, and it says something about cruel and unusual punishment.

The court, in Driver versus Hinnant, said that for North Carolina to apply a public intoxication statute to a chronic alcoholic, was for North Carolina to violate the eighth amendment and that the eighth amendment applied to North Carolina and all the other states. It sounds like good reasoning and, as I say, I agree with the result. In the DeWitt Easter Case we didn't have a problem of the applicability of the eighth amendment because in the District of Columbia, the federal courts assume the posture of local courts. The local law is the federal law. We didn't have to use the fourteenth amendment: The court directly applied the eighth amendment to the case by this process of reasoning. Four of eight judges in that court said that it was cruel and unusual to arrest a chronic alcoholic. The other four reached the same result under common law principles.

What is wrong with this? Well, this is what is wrong, in my opinion. Basically a public intoxication statute is not addressed to intoxication or public intoxication. When our community, starting in England in 1600, began to enact public intoxication statutes, the object was not alcohol, it was not drunkenness. The object

(Continued on page 29)

Sheltered Workshop

We would like very much to receive *Inventory* every quarter. Could we be placed on a permanent mailing list?

The Sheltered Workshop for the Handicapped, Inc.
Lexington, N. C.

Deals With Families

As a physician practicing in a small town I deal with a number of alcoholics and find that dealing with families can be as frustrating as dealing with the alcoholic.

Your "A Guide for the Family of the Alcoholic" by Rev. Joseph L. Kellermann has been most helpful to me. May I obtain a number of copies of this pamphlet to keep in my waiting room? Any other material which you might have will be greatly appreciated.

An Anonymous Physician
A Town in Georgia

Home Nursing Service

I would be most pleased if you would put me on the mailing list for the quarterly publication, *Inventory*. I feel that it would be most helpful and informative for our staff.

Sister Mary Jogues
Home Nursing Service
Hayesville, N. C.

AA, Al-Anon and Alateen

I enjoy reading *Inventory* which comes to a neighbor. My husband is active in AA and I in Al-Anon. We are setting up the first Alateen group in our immediate area, and I would like to receive your magazine. Could I get a copy of the Oct.-Dec., 1968 issue? An article by my husband's doctor appeared in it.

Anonymous
Mt. View, California

Member of Task Force

As a member of the Task Force on Alcoholism of the California Council on Criminal Justice, I would be most appreciative if you would place me on the mailing list for your magazine, *Inventory*.

Mrs. Richard Goates
Palos Verdes Ests., California

Industrial Counseling Service

Our service is sponsored by 17 Greensboro industries to provide help for alcoholic employees and their families. *Inventory* has always been helpful to me, and I would like to receive it.

Rev. Nelson B. Hodgkins
Industrial Counseling Service
Greensboro, N. C.

Science Teacher Writes

I would appreciate your putting my name on your mailing list for *Inventory* as I would like to have the copies for use in my anatomy and physiology classes. Last year when I had a copy on the magazine rack, several students showed interest in borrowing it. I think that they can carry it to places where it can do good. Of course, the information is helpful to the students also.

Claire Freeman, *Chairman*
Science Department
Jesse O. Sanderson High School
Raleigh, N. C.

of those statutes was and is a condition of human inadequacy. The community, society, was concerned about the fact that there were in the midst of us a minority of individuals who for a variety of reasons were unequal to life's challenge. We broadly call them skid row bums or derelicts.

Oh yes, drink does tend to be symptomatic of the derelict's degradation. They drink for a variety of reasons. As any group—doctors, lawyers, shoemakers, candlestick makers—there are in a skid row population a percentage of compulsive drinkers. I say a percentage. I often wonder whether that percentage is greater than in other groups. I suspect, and I don't think anyone knows, that many of the deviate drinkers on skid row are not alcoholics. They are excessive drinkers who are attempting to blot out the extreme degradation in which they find themselves. They can't adjust to life and they find a degree of support, a degree of rapport if you will, through the use of wine or some other liquid. This is pointed out by Dr. Robert Strauss, the distinguished sociologist, one who has been interested in this problem for many years, when he describes them as plateau drinkers as distinguished from chronic alcoholics.

You will recognize that many of our alcoholic friends, when they indulge in drink, tend to seek oblivion. When they make the mistake of taking that first drink and the compulsion is alive, they seek oblivion, they seek to pass out. On the contrary, the lad on skid row more often than not takes the bottle of wine out, he raises his intake to a point where reality is crowded out and serenity replaces it and, at that point, he puts the bottle of wine in his back pocket. He's happy for an hour or two. The plateau recedes and reality begins to enter again at which point he takes out the bottle of wine and he again reaches his plateau of peace. Now this is a different type of deviate drinking than the compulsive drinker. Then, of course, there are many on skid row who are considerably under the weather simply because there aren't a great many things to do; this is the culture of skid row. Whether they are chronic alcoholics is very doubtful indeed.

The Driver and Easter cases are confined to chronic alcoholics. You might well ask the question if the rationale of the Driver and Easter cases is valid, how about the chronic alcoholic who gets drunk in public at a time when his compulsion is not active? Those of us who are interested in alcoholism know that every time a chronic alcoholic gets drunk it isn't the result of his compulsion. There are many times when the chronic alcoholic is in a physical condition to drink normally. In the courts are we first to determine whether he is a chronic alcoholic, and secondly whether this particular state of intoxication is the result of his compulsion? Rather I say, we should recognize that public intoxication statutes reflect a concern not about drunkenness, but rather incapacity to live. We, the more fortunate in society, from time to time are getting together the derelicts and putting them in cells only because we don't have a more adequate answer to their helplessness. This is society's excuse for a more meaningful approach to extreme welfare need. This is an anachronism in society.

Starting in the 1930's we have been proud increasingly to become, I say, a welfare state, to recognize that society has a greater responsibilty to provide for the needy. But the skid row derelict has always been blotted

out of that recognition. He was denied the recognition that he had an equal right to the person in a more normal situation. I say the statute is directed at his condition of inadequacy, not his drunkenness. A public intoxication statute is directed at a status, not the status of alcoholism, but the status of human inadequacy, and it is for this reason that I say that the public intoxication statute is unconstitutional. The fourteenth amendment does say that no state shall violate due process of law and when we enact a criminal statute directed at human need, then we do, on basic elementary justice, violate that amendment. That is why the Driver and Easter cases are right, not for the reasons set forth by the courts.

Presently, the entire matter is before the Supreme Court of the United States. It is my prayer that in the case of Powell against Texas, which will be decided by the court in a month or two, the decision of the court will be that there should again be a reversal of the conviction, but I hope the Supreme Court of the United States will be inspired to recognize the true dynamics of the drama lying underneath the facts in the case, and make that reversal stand on true basic justice under the fourteenth amendment.

Why do I feel so strongly on this? In the criminal law, we have long said that intoxication, at least insofar as it is self-willed, is no defense to a crime. This is traditional and almost as unshaken as belief in public intoxication statutes were up to this date. Now in Driver and Easter the courts seem to r e c o g n i z e the validity of this dogma and almost refuse to say that they are carving out an exception to that general principle in the case of chronic alcoholics. I disagree. They are carving out an exception. Worse than that, they are confusing what is already confused and unjustifiable doctrine. The traditional doctrine that intoxication is no defense to a crime calls for reanalysis. Let us t h i n k for a moment. Suppose I am under the weather. I am really three sheets to the wind, and I commit an act which, were I sober, would be a crime, yes, an extreme felony. I am prosecuted. The court applies the traditional philosophy that intoxication is no defense to the commission of a crime. I am convicted and sentenced like any felon. Mind you, I assume that if were I sober, I wouldn't have done this but the traditional law is applied, I am convicted and I am punished.

I ask this audience, am I not being punished not for the crime, but rather for having gotten drunk? Certainly there are many in the audience who tied one on from time to time. Do any of you feel that if, through no fault of your own, you have done something serious, you should have been given a long period of incarceration for your getting intoxicated? I don't commend intoxication, but I urge the law as a matter of abstract logic to recognize that the sin of getting intoxicated is not so extreme as to commend severe punishment. I rather suggest that this traditional philosophy, that intoxication is not a defense to a crime, reflects the age old intolerance of liquor, the kind of intolerance that gave birth to the eighteenth amendment.

I suggest that we need a reanalysis. Now many times a person is intoxicated, commits a crime and should be punished because his intoxication was not so extreme. Contrariwise, there doubtless are many decent people who in a complete state of intoxication do something which from the standpoint of the intellect

is not theirs, from the standpoint of volition is not theirs. How can we therefore justify punishment of those people? I mention this because my quarrel with Driver and Easter Cases is not alone that the courts neglected to analyze the problem and declare the statutes unconstitutional as to all individuals on fundamental rationale but also because it is a means of delaying a reexamination of a legal dogma that cries for reexamination.

It is only in the last several decades that there has been a more or less general recognition of a pathology known as alcoholism. Oh yes, we can get back over the centuries and find isolated thinkers who seemed to perceive that alcoholism was pathological. But anything like the modern recognition of alcoholism as a disease is relatively new. The Driver and Easter cases, I make bold to suggest, are a reflection of this sudden awareness of something new and something different, but regretfully an inadequate or a superficial recognition. The learned judges who made these decisions had good intentions and were motivated by what they thought was new doctrine. But understandably they don't identify with the derelict and they confuse alcoholism with something that is not really alcoholism. We need a recognition that public intoxication statutes are unconstitutional because they are directed not at drink or alcoholism, but rather human inadequacy and yes, we need a legal and judicial breakthrough on the total field of the responsibility of all, be they alcoholics or nonalcoholics, for crimes committed in a condition of intoxication. This is sought, not because of our interest in alcoholics, great though that should be, but because as a matter of justice it is strongly indicated.

INTERNATIONAL OVERVIEW

CONTINUED FROM PAGE 12

is highly permissive. One attitude survey of French people, although somewhat outdated by a 1953 publication mark, reported that for a man doing physical work, 25 per cent felt wine was indispensable; 63 per cent classified wine as useful; 70 per cent, nourishing; and 80 per cent, felt wine was good for the health.

Furthermore, France has the highest per capita rate of alcohol consumption in the world, and "in Europe, the highest rates of alcohol addiction and deaths due to alcoholic cirrhosis of the liver." In a lecture at the 1963 European Institute on Alcoholism at Lausanne, Professor Fouquet has provided an excellent analysis of the French problem with an emphasis upon the economic factors. What role does the production of alcohol and spatial distribution of its production and consumption have on the genesis of alcoholism? These factors have largely been ignored by Americans. In France, Fouquet reports that at least three and one-half million people are engaged in viticulture and the production and distribution of alcoholic beverages. Fouquet supports his contention that there is a relationship between the economic factor of production, alcoholization, and alcoholism by referring to the noted French study of Ledermann, Trevas and Hong, which shows that the commitments for alcoholic psychoses vary directly with density of home production of alcoholic beverages or the importance of winegrowing. This study indicates with others that indirectly the French population is permissive not only to alcohol beverage production but the pathologies that develop from its excessive ingestion.

To be continued next issue.

DIRECTORY OF OUTPATIENT FACILITIES BY COUNTY —for ALCOHOLICS and/or THEIR FAMILIES

Key to Facilities

+ Community Alcoholism Program
(supported jointly by the community and the N. C. Department of Mental Health)

*** Community Alcoholism Program**
(supported largely by funds from local boards of alcoholic beverage control)

‡ Joint Mental Health and Alcoholism Facility
(supported by the community and the N. C. Department of Mental Health)

† Mental Health Facility
(supported by the community and the N. C. Department of Mental Health whose services are available to alcoholics and their families)

Competent Help Is Available At The Local Level

ALAMANCE—

+ *Alamance County Council on Alcoholism,* Room 802, N. C. National Bank Bldg., Burlington 27215; Tel: 919-226-4403.

† *Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd., Burlington 27215, Tel: 919-227-6271.

ALLEGHANY (See Watauga)

ANSON—

† *Anson County Health Department,* Wadesboro 28170, Tel: 704-694-2516.

* *Education Division, Board of Alcohol Control,* 125 Wade St., P. O. Box 29, Wadesboro 28170, Tel: 704-694-2711.

AVERY (See Watauga)

BERTIE (Hertford)—

+ *Roanoke-Chowan Alcohol Information and Service Center,* 111 Belmont St., P. O. Box 143, Windsor 27983, Tel: 919-794-2895.

BEAUFORT (Hyde, Martin, Tyrrell, Washington)—

† *Tideland Mental Health Center,* 418 West Second St., Washington 27889; Tel: 919-946-4640.

BLADEN (See Robeson)

BUNCOMBE—

+ *Alcohol Information Center,* Parkway Offices, Asheville 28802, Tel: 704-252-8748.

† *Mental Health Center of Buncombe County,* 415 City Hall, Asheville 28801, Tel: 704-254-2311.

BURKE—

* *Burke County Council on Alcoholism,* 211 N. Sterling St., Morganton 28655; Tel: 704-443-1221.

CAMDEN (See Pasquotank)

CARTERET (See Craven)

CABARRUS—

† *Cabarrus County Mental Health Clinic,* 102 Church St., N.E., Concord 28025; Tel: 704-786-1181.

CATAWBA—

* *Catawba County Council on Alcoholism,* 420 Seventh Ave., S. W., Hickory 28601; Tel: 704-328-3564.

CHOWAN (See Pasquotank)

CLEVELAND—

† *Cleveland County Mental Health Clinic,* 101 Brookhill Rd., Shelby 28150; Tel: 704-482-3801.

CRAVEN (Carteret, Jones, Pamlico)—

‡ *Neuse Mental Health and Alcoholism Center* (Craven County Hospital, New Bern 28560; Tel: 919-638-5173, Ext. 294)

+ *Division on Alcoholism,* 411 Craven St., P. O. Box 1466, New Bern 28560; Tel: 919-637-5719.

+ *Division on Alcoholism,* 506 Broad St., P. O. Box 82, Beaufort 28516; Tel: 919-728-4033.

COLUMBUS (See Robeson)

CUMBERLAND—

† *Cumberland County Mental Health Center*:

+ *Division on Alcoholism,* Cape Fear Valley Hospital, Fayetteville 28302; Tel: 919-484-8123.

DARE (See Pasquotank)

DURHAM—

† *Department of Psychiatry,* Duke University Medical Center, Durham 27706; Tel: 919-684-8111, Ext. 3416.

* *Durham Council on Alcoholism,* 602 Snow Bldg., Durham 27702; Tel: 919-682-5227.

EDGECOMBE (Nash)—

† *Edgecombe-Nash Mental Health Clinic*

+ *Division on Alcoholism,* 228 Hammond St., Rocky Mount 27801; Tel: 919-442-8021.

FORSYTH—

† *Department of Psychiatry, Bowman Gray School of Medicine,* N .C. Baptist Hospital, Winston-Salem 27103; Tel: 919-725-7261.

† *Forsyth County Department of Mental Health*:

+ *Alcoholism Program of Forsyth County,* 802 O'Hanlon Bldg., 105 W. 4th St., Winston-Salem 27101; Tel: 919-725-5359.

† *Forsyth County Mental Health Unit,* 1020 E. 7th St., Winston-Salem 27101; Tel: 919-722-0364.

GASTON—

† *Gaston County Mental Health Center:*
+ Center For Alcohol Related Problems, 302 S. York St.; Gastonia 28052; Tel: 704-864-9771.

GUILFORD—

* *Alcohol Education Center,* P. O. Box 348, Jamestown 27282; Tel: 919-454-2794.

Family Service Agency, 1301 N. Elm St., Greensboro 27401; Tel: 919-273-0523.

Family Service of High Point, 113 Gatewood Ave., High Point 27260; Tel: 919-883-1709 or 919-833-2119.

+ *Greensboro Council on Alcoholism,* 216 W. Market St., 206 Irvin Arcade, Greensboro 27401; Tel: 919-275-6471.

† *Guilford County Mental Health Center,* 300 E. Northwood St., Greensboro 27401; Tel: 919-273-8281.

† *Guilford County Mental Health Center,* 942 Montlieu Ave., High Point 27262; Tel: 919-888-9929.

HALIFAX—

† *Halifax County Mental Health Center,* 701 Jackson St., P. O. Box 577, Roanoke Rapids 27870; Tel: 919-537-6174.

HARNETT (See Lee)

HENDERSON—

* *Alcohol Information Center,* 2nd floor, City Hall, P. O. Box 472, Hendersonville 28739; Tel: 704-692-8118.

† *Henderson County Mental Health Clinic,* 820 Fleming St., Hendersonville 28739; Tel: 704-692-2138.

HERTFORD (See Bertie)

HOKE (See Moore)

HYDE (See Beaufort)

IREDELL—

† *Iredell County Mental Health Clinic,* 221 South Center St., Statesville 28677; Tel: 704-872-7901.

JONES (See Craven)

LEE—

† Lee-Harnett Mental Health Clinic:
+ *Division on Alcoholism,* 106 W. Main St., P. O. Box 2428, Sanford 27330; Tel: 919-755-4129 or 919-755-4130.

MARTIN (See Beaufort)

MECKLENBURG—

* *Charlotte Council on Alcoholism,* 1125 E. Morehead St., Charlotte 28204; Tel: 704-375-5521.

† *Mecklenburg County Mental Health Center,* 316 E. Morehead St., Charlotte 28202; Tel: 704-334-2834.

* *The Randolph Clinic, Inc.,* 1804 East Fourth St., Charlotte 28204; Tel: 704-333-9026.

MONTGOMERY (See Moore)

MOORE—

* *Moore County Alcoholism Program,* P. O. Box 1098, Southern Pines 28387; Tel: 919-692-6631.

† *Sandhills Mental Health Center* (Hoke, Montgomery, Moore, Richmond):

+ *Alcoholism Services,* Medical Center Building, Pinehurst 28374; Tel: 919-295-6851.

NASH (See Edgecombe)

NEW HANOVER—

* *New Hanover County Council on Alcoholism,* 211 N. Second St., Wilmington 28401; Tel: 919-763-7732.

† *Southeastern Mental Health Center,* 920 S. 17th St., Wilmington 28401; Tel: 919-763-7342.

ORANGE—

† *Alcoholism Clinic of the Psychiatric Out-Patient Service, N. C. Memorial Hospital,* Chapel Hill 27514; Tel: 919-942-4131, Ext. 336.

* *Orange County Council on Alcoholism,* Box 277, Carrboro 27510; Tel: 919-942-1089 or (if no answer) 919-942-1930.

PAMLICO (See Craven)

PASQUOTANK (Camden, Chowan, Dare, Perquimans)—

‡ *Mental Health and Alcoholism Authority:*

+ *Division on Alcoholism,* P. O. Box 645, Medical Bldg., Elizabeth City 27909; Tel: 919-335-1663.

PERQUIMANS (See Pasquotank)

PITT—

† *Coastal Plain Mental Health Center,* 1827 W. Sixth St., Greenville 27834; Tel: 919-752-7151.

+ *Pitt County Alcohol Information and Service Center,* 907 Forbes St., P. O. Box 2371, Greenville 27834; Tel: 919-758-3159.

RICHMOND (See Moore)

ROBESON (Bladen, Columbus, Scotland)—

† *Southeastern Regional Mental Health Center,* Medical Arts Bldg., Lumberton 28358; Tel: 919-739-7601.

ROCKINGHAM—

+ *Rockingham County Mental Health Center,* P. O. Box 55, Wentworth 27375; Tel: (919) 349-7021.

ROWAN—

* *Educational Division, Rowan County ABC Board,* P. O. Box 114, Salisbury 28144; Tel: 704-633-1641.

† *Rowan County Mental Health Clinic,* Community Bldg., Main and Council Sts., Salisbury 28144; Tel: 704-633-3616.

SCOTLAND (See Robeson)

TYRRELL (See Beaufort)

VANCE—

† *Vance County Mental Health Clinic,* County Home Rd., Henderson 27536; Tel: 919-492-1176 or 919-438-4813.

* *Vance County Program on Alcoholism,* 158 Bypass W., P. O. Box 1174, Henderson 27536; Tel: 919-438-3274 or 919-483-4702.

WAKE—

† *Mental Health Center of Wake County,* Wake Memorial Hospital, Raleigh 27610; Tel: 919-834-6484.

* *Wake County Health Department,* 3010 New Bern Ave., Raleigh 27610; Tel: 919-833-1655.

WASHINGTON (See Beaufort)

WATAUGA (Alleghany, Avery, Wilkes)—

† *New River Mental Health Center:*

+ *Division on Alcoholism,* 210 W. King St., Boone 28607; Tel: 704-264-8759.

+ *Division on Alcoholism,* 101-A W. Main St., Wilkesboro 28697; Tel: 919-838-3551.

WILSON—

Aftercare Clinic, Encas Rural Station, Wilson 27893; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.; Tel: 919-237-2239.

* *Wilson County Council on Alcoholism,* Room 308, 116 S. Goldsboro St., Wilson 27893; Tel: 919-237-0585.

Wilson Mental Health Clinic, Encas Rural Station, Wilson 27893; Tel: 919-237-2239.

WILKES (See Watauga)

EDUCATION AND INFORMATION SERVICES

INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Teacher's Guide—kit containing reference material and pamphlets on alcoholism and mental health. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C. 27603

Second - Class
Postage Paid at Raleigh, N. C., 27602.